

Medical Support Orders

Agency Benefit Coordinator
Virtual Training


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Service Center Manager

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Medical Support Order

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities.



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Medical Support Order

Employer's Response:

The employer has 20 business days from the date of the notice to complete sections 1,2, 3, 4 or 5 if applicable and return to the issuing agency.
If section 6 or 7 is selected, the entire order including the employer response page should be sent to Benefits Administration.

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward Part B to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this Employer Response regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

- ☐ 1. The employee named in this Notice has never been employed by this employer.
- ☐ 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.
- ☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.
- ☐ 4. Health care coverage is not available because employee is not employed by employer:
Effective date of termination: _____
Reason for termination: _____
Last known telephone number: _____
Last known address: _____
New employer (if known): _____
New employer telephone number: _____
New employer address: _____
- ☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.
- ☐ 6. The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the Plan Administrator will process the enrollment.
- ☐ 7. Employer forwarded Part B to Plan Administrator on _____ MM/DD/YYYY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____ FAX Number: _____
Contact Person: _____ Telephone Number: _____
Employer Name: _____ Telephone Number: _____
Employer Representative Name/Title: _____ Federal EIN: _____
(If not provided on Page 1 of this Notice)
Employer Name: _____ Date: _____

NAME - Part A

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Medical Support Order

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

Case # _____ (to be completed by the issuing agency)

This Notice was received by the plan administrator on _____.

- 1. This Notice was determined to be a "qualified medical child support order," on _____, Complete Response 2 or 3, and 4, if applicable.
- 2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage:
 - a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
 - b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
 - c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
 - d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of _____ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option (if plan is insured, identify provider, policy and group numbers): _____. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

- 3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: _____.

- 4. The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the plan administrator will process the enrollment.

- 5. This Notice does not constitute a "qualified medical child support order" because:
The name of the child(ren) or participant is unavailable.
The mailing address of the child(ren) (or a substituted official) or participant is unavailable.
The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan: _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____
Title: _____ Date: _____
Address: _____

NAME - Part B

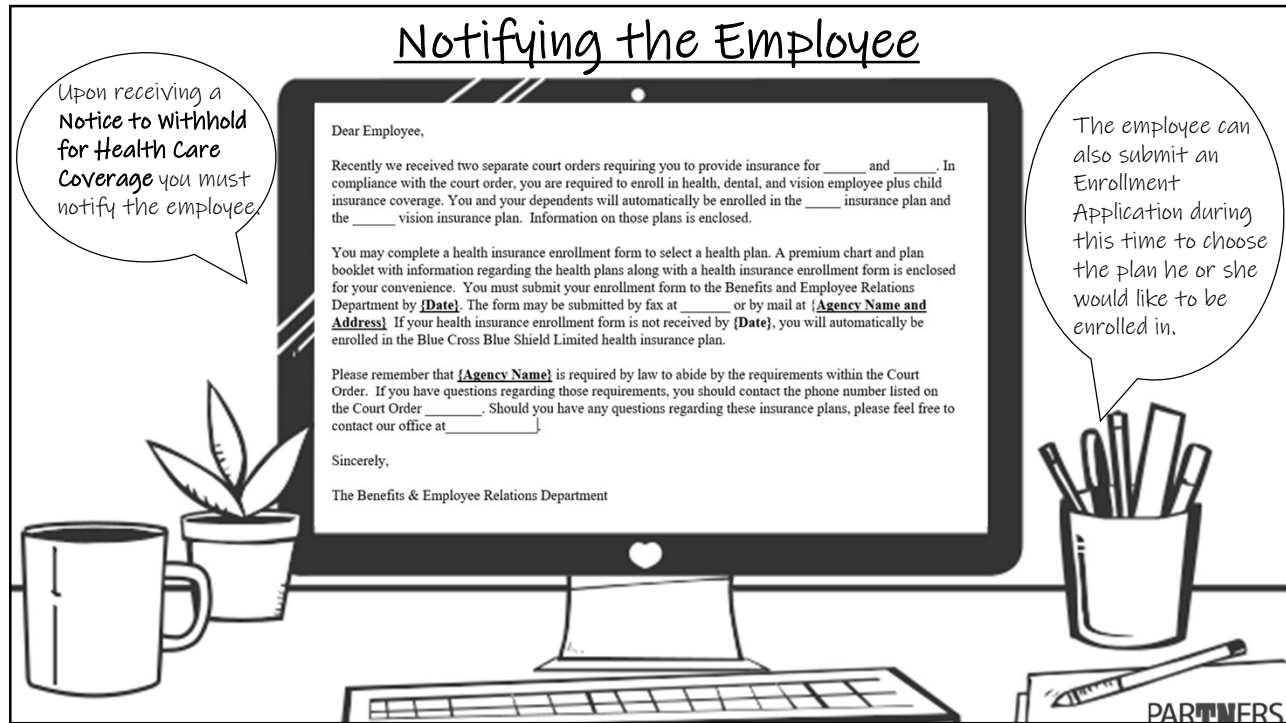
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Plan Administrator: BA

The plan has 40 business days from the date of the notice to enroll the court ordered dependent and notify the issuing agency, custodial parent, and employee.
The plan administrator page within the order must also be completed.

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Employer Response: What will you need to do?

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward **Part B** to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this **Part A** to the Issuing Agency if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.

☐ 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

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Employer Response: Continued...

☐ 6. The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the Plan Administrator will process the enrollment.

☐ 7. Employer forwarded Part B to Plan Administrator on _____
MM/DD/YY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____	FAX Number: _____
Contact Person: _____	Telephone Number: _____
Employer Name: _____	Telephone Number: _____
Employer Representative Name/Title: _____	Federal EIN: _____
	(if not provided on Page 1 of this Notice)
Employee Name: _____	Date: _____

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Cost Limitations

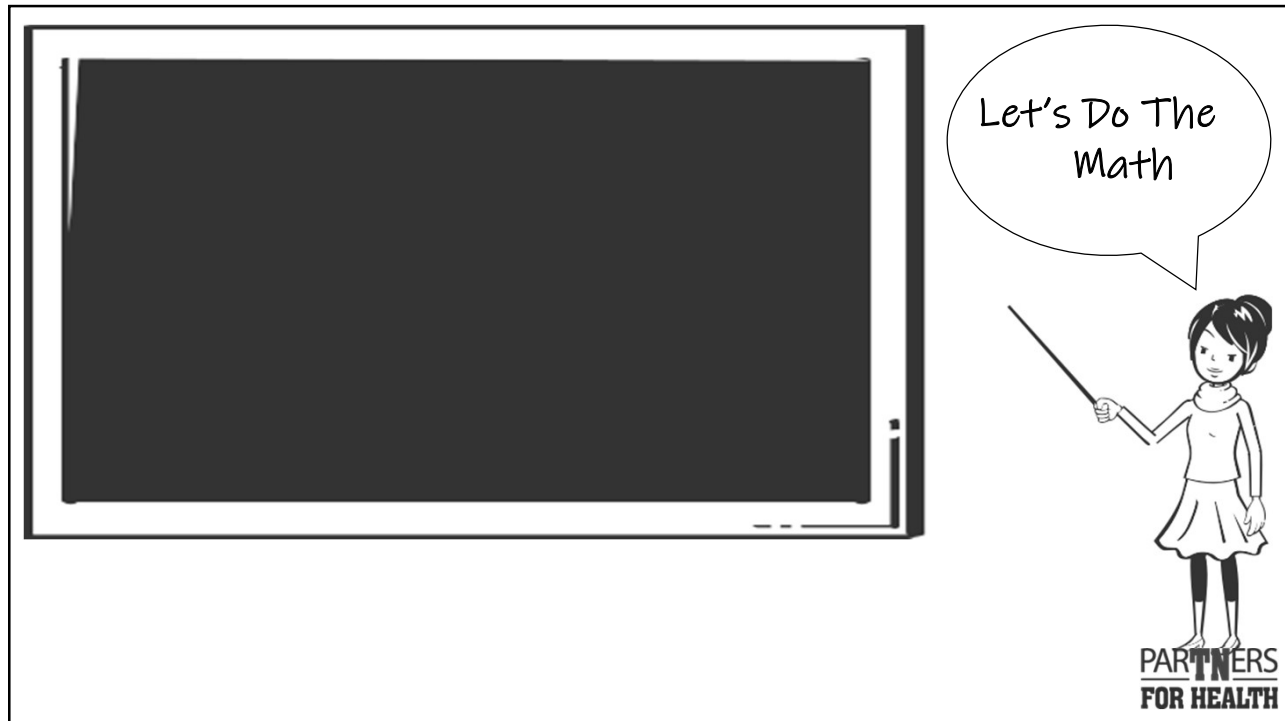
The Federal limit applies to the aggregate disposable weekly earning (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes, Social Security taxes, and Medicare taxes.

- ☐ You must complete this section before sending to Benefits Administration, if applicable.
- ☐ The total amount withheld for both cash and medical support cannot exceed 50% of the employee's aggregate disposable weekly earning.

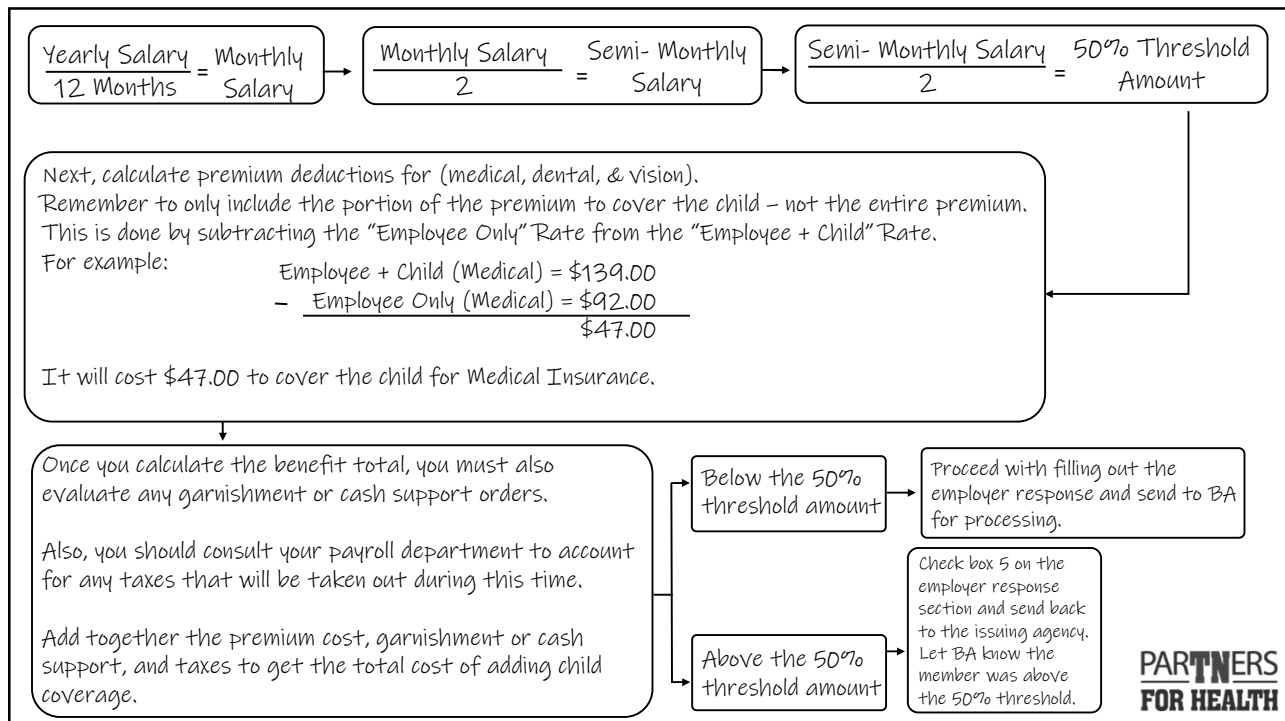


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Let's Do the Math

\$ 29,260.00 Annually

Employee + Child Health=\$139.00 - Employee Only =\$ 92.00
(\$47.00)

Employee + Child Dental=\$27.91 - Employee Only= \$13.44
(\$14.47)

Employee + Child Vision= \$6.13

Total Cost to add child is **\$67.60**

Garnishment/Income Support of per paycheck: \$200

Taxes: \$200

Total: \$467.60

Divide \$29,260 / 12= \$2,438 per month

Divide Monthly \$2,438 / 2 = \$ 1,219 bi-weekly pay

Divide bi-weekly pay \$1,219 / 2 = \$609.50

~~\$609.50~~ 50% threshold that we must stay below

- ☐ Proceed with the process, complete the employer response page and forward the entire order to BA.

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Let's Do the Math

\$ 22,000 Annually

Divide \$22,000 / 12= \$1,833 per month

Divide Monthly \$1,833 / 2 = \$916.50 bi-weekly pay

Divide bi-weekly pay \$916.50 / 2 = \$458.25

~~\$458.25~~ 50% threshold that we must stay below

Employee + Child Health = \$139.00

Employee + Child Dental = \$27.91

Employee + Child Vision = \$6.13

Total Cost to add child is **\$173.04**

Garnishment/Income Support of per paycheck: \$200

Taxes: \$200

Total: \$573.04

- ☐ Member is over the 50% threshold limit. Ask member if they would still like to add the child. If they do not, check box 5 on the employer response and send back to court.

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Duration of Coverage



- ❑ Once a dependent is covered by a Medical Support Order, the dependent can only be released from the order through an order from the court.



- ❑ If a release is provided, the employee does have the option to continue coverage for the dependent until they turn 26.

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Release of Medical Support Order

The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided with satisfactory written evidence.

Or;

2. The employer eliminates family health coverage.

NOTICE OF RELEASE OF MEDICAL SUPPORT	
Issuing Agency: CHILD SUPPORT SERVICES Issuing Agency Address: Telephone Number: FAX Number:	Court or Administrative Authority: CHANCERY Court Date of Support Order: Support Order Number: Case Number: Date of Notice:
Employee/Withholder's Federal EIN:	Employee's Name (Last, First MI):
Employee/Withholder's Name:	Employee's Social Security Number:
Employee/Withholder's Address:	Employee's Mailing Address:
You are no longer required to enroll the children listed below in a health insurance plan based on our notice. However, do not automatically drop these children from coverage. Check with the employee listed above before taking any action.	
Child(ren)'s Name(s)	DOB SSN

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Release of Medical Support Order

- ☐ If you receive a release and the employee opts to disenroll the child:
 - ☐ Complete a cancel request, send to BA with a copy of the release.
- ☐ If the employee wants to continue coverage you will need to notify BA.



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Reasons for Correspondence



- ☐ Court Ordered Dropped Query
- ☐ New Hire Enrollment
- ☐ Court Ordered Termination Query
- ☐ Orders submitted directly to BA

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Questions?



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